



Claimant's Name: _____ SSN: _____ Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

HEARING POSTPONED

Employee _____

Employer _____

Carrier _____

Attorneys _____

Other Parties _____

TO THE PARTIES ADDRESSED:

You are hereby notified that hearing on the above-stated case is postponed.

When the case has been reassigned for hearing, the interested parties will be duly advised of the date.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

By: _____

Code numbers furnished each employer and carrier should be inserted before mailing. Refer to Docket File No. in all correspondence about this injury.